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The Nearest Relative in the Mental Health Act 2007: Still an illusionary and inconsistent safeguard?

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Abstract

The role of Nearest Relative is intended as a safeguard in the Mental Health Act 1983 (as amended in 2007) to curb the excesses of professional discretion and protect patients from unwarranted compulsory hospitalisation. It is unique to the mental health compulsory detention process in England and Wales. There are, however, evident tensions in the role and a lack of clarity surrounding the precise functions of the nearest relative. There is also some uncertainty and confusion among practitioners about the scope of the nearest relative involvement. Despite longstanding concerns about the role, there is remarkably little published research available to date on its use and effectiveness, in so far as evaluating the extent to which it provides an adequate safeguard for patients, as intended by the legislation. This article will briefly explore the background to the role, highlight some of the difficulties and tensions within it and conclude with some observations about where further research and reform may be needed to provide greater protection and clarity for patients, relatives and health and social care practitioners.

Key words: *Mental Health Act – nearest relative – patient rights - safeguard – Approved Mental Health Professional – families and carers*

Introduction and background to the Nearest Relative role

The World Health Organisation's 'Resource Book on Mental Health, Human Rights and Legislation' recognises that the involvement of relatives and carers with persons with mental disorders varies significantly among different countries and cultures. Nevertheless, it is common for families and carers to assume major responsibilities for looking after persons with mental disorders and the World Health Organisation advises that national legislation needs to reflect this (WHO, 2005: 39). The Mental Health Act (MHA) in England and Wales does recognise this by giving certain relatives legal rights to be directly involved and play an active role (as a designated Nearest Relative (NR)) in the compulsory admission process. The MHA regulates the legal framework for providing compulsory mental health treatment to persons with a mental disorder in England and Wales. The MHA sets out the criteria and procedures for compulsory admission to, and treatment in, hospital, as well as outlining the various duties and responsibilities of relatives and key professionals, such as social workers and psychiatrists, in those processes.

This imperative for active involvement of relatives/carers sits well with recent government policy in the UK, which has reaffirmed the important role that carers and family members play in patient¹ care (Department of Health, *Recognised, Valued and Supported: next steps for the carers strategy* (2010)). The advent of the Care Act in 2014 reinforced the key role filled by carers and created entitlements for carers to receive support. Furthermore, in recognition of the tremendous contribution of unpaid carers, the current Conservative government has recently consulted on a new strategy to improve the support provided to informal carers.² It is therefore timely to take a closer look at the involvement of relatives (who may or may not be carers) in the compulsory mental health care process in the light of the government's commitment to strengthen the support and involvement of carers in the provision of health and social care more generally. This need is reinforced by the government's recent announcement in the Queen's Speech that it intends to review the current MHA with a view to introducing a new Mental Health Treatment Act.³ It is also

¹ The term 'patient' is used here, as opposed to service user, and is in line with the terminology used in the MHA.

² Located at <https://www.gov.uk/government/consultations/carers-strategy-call-for-evidence> (accessed 9.4.2017).

³ See Queen's Speech 2017 (21 June 2017) located at <https://www.gov.uk/government/speeches/queens-speech-2017>; 'Conservatives pledge to scrap "flawed" Mental Health Act', Community Care, 8 May 2017; 'Theresa May unveils biggest shake-up of mental health policies in 30 years, The Independent, 17 May 2017.

apposite to re-appraise the role if we consider the context of MHA detentions and the growing number of compulsory admissions in England and Wales during the last decade (NHS Digital, 2016), which raise further questions about the use of compulsory admission powers and the involvement of relatives in that process.

The NR involvement in the mental health compulsory admission process has its roots in the recommendations of the Percy Commission (*Royal Commission on Law relating to Mental Illness and Mental Deficiency* 1957 Cm 690). The Percy Commission recognised that relatives are often the first to identify symptoms as well as the need for contact with mental health services. The Percy Commission report led to the introduction of the Mental Health Act in 1959, which placed the NR on a statutory footing. The government at the time clearly felt that it was an important safeguard against unwarranted hospitalization, thus, formal powers were accorded to relatives to detain and discharge patients which remain intact in the current mental health statutory framework.

The NR role has survived various attempts at reform since the MHA 1959. It was retained in the MHA 1983; however, it did come under considerable scrutiny during the reform process in the late 1990s/early 2000s, which culminated in the passing of the MHA 2007. Key concerns focused on: the extent to which patients could exercise autonomy over the choice of relative for the role; the out-dated hierarchical list of relatives suitable to act as such; as well as issues around public and professional awareness, tensions and (mis)understanding about the role (Spencer-Lane, 2011; Andoh & Gogo, 2004; Yeates, 2005). Despite the concerns, some proponents felt strongly that the presence of the NR can act as a strong counterbalance to professional opinion in the compulsory admission process. It can also help to promote the least restrictive alternative principle in the MHA, as this quote from Yeates (2005: 125) demonstrates:

‘At a time when a person’s mental health is in crisis, they will benefit from someone who has a close connection and who can support the case for care in the least restrictive setting, in short, the case against compulsory hospitalisation. The nearest relative concept provides this’.

The reform process was protracted and, in the light of responses from key stakeholders, various suggestions for amendments to the role were made. The government ultimately did not agree with the need for wholesale reform and the NR remained essentially intact, albeit with some modifications, primarily because of human rights concerns expressed during the reform process. The precise functions and duties of the NR, as well as these recent modifications to the role, are considered in more detail below.

The Nearest Relative's Duties and Powers

This section seeks to highlight and thoughtfully consider key aspects of the NR role in the compulsory admission process. Ordinarily an Approved Mental Health Professional⁴ (AMHP) is the person who makes the decision as to whether a person is detained or not, but the NR can also make this decision by completing the relevant paperwork if the AMHP will not. As such, the NR is one of several key roles found in the MHA 1983 (as amended in 2007),⁵ all of which have specific duties and powers to influence where and how a person's compulsory mental health treatment is provided. The NR is typically a family member, as listed in a hierarchy set out in section 26 MHA⁶, and not a qualified professional or expert. In some circumstances, a non-relative can be appointed by the County Court to act as a NR and this will be discussed further below. However, as the title 'NR' suggests, the MHA intends that the functions are fulfilled by a family member.

The functions of the NR can be broadly categorised into three key areas. First, under section 11(4), the NR can prevent detention by stating they 'object' to an AMHP completing the application for compulsory admission under section 3⁷ MHA to detain the person in hospital (or under section 7⁸ MHA to receive them into guardianship (i.e. care & treatment) in the community). The MHA draws the distinction between seeking the NR's permission to detain

⁴ The Approved Mental Health Professional is a specialist role held by a social worker, occupational therapist, mental health nurse or chartered psychologist who is specially trained.

⁵ Alongside the *Mental Health Act 1983: Code of Practice* (DH 2015) and *Reference Guide to the Mental Health Act 1983* (DH 2015).

⁶ Section 26 lists a hierarchy of relatives, who will be considered to be the NR, though note that 'cousin' and 'great' uncle or aunt are excluded, unless appointed by the court.

⁷ Admission for treatment in hospital for up to six months.

⁸ Application for guardianship in the community.

and establishing that they do not object. A subtle difference perhaps but nonetheless empowering to the NR to act in this way, if they were not requesting the MHA assessment in the first place. The objecting NR can be removed through a displacement process (and the functions given to a non-objecting NR by the County Court instead), but only if the objection is deemed by the court to be unreasonable. In this sense, the power to object could be viewed as an essentially procedural safeguard, as it can be side-stepped in such circumstances.

Secondly, under section 13(4) MHA, the NR can challenge⁹ the lack of initiation of a formal application under the MHA by requesting a MHA assessment. Typically this may be when the NR feels that community mental health services are not being responsive or effective. If a MHA is declined by the local authority, a response in writing must be given to the NR. The NR's request for an assessment can be driven by a variety of reasons, ranging from beneficence to malice, and the AMHP should seek to explore this when a referral by the NR is made. Doctors are advised that they should inform the NR of their right to request an assessment and should direct them accordingly. Equally, the NR can (as part of an assessment) also challenge whether all the 'least restrictive' options (e.g. voluntary or home treatment) have not already been considered, when compulsory admission is being discussed (DH 2015:14.7). As referrals can often come from concerned and exhausted family members, it is likely that these alternatives will have been explored already, although issues may have arisen where an identified psychiatric bed is out of area and some distance away. The NR does not need to be the person who is caring for the patient in the community or even had recent involvement in their care. In fact, the person who is identified as the NR may be someone who has not had any contact with the patient for some time, or someone who does not wish to be the NR at all. However, section 26(4) does make an assumption that those who 'care for' or 'reside with' the person being assessed may be more likely to act in the persons best interests, compared with those who do not. Moreover, the MHA aids this class of relative (carer or relative in residence) by promoting their ability to be a NR over other relatives.

⁹ The term challenge is used here to describe the fact that the NR can seek to access a mental health assessment and appropriate (i.e. the least restrictive) treatment /care for the patient.

There is clear potential for a conflict of interest where the NR wants their relative to be in hospital, as they are unlikely to offer a challenge to the professional decision makers. Therefore, the importance of the dialogue between the AMHP, doctors and NR extends beyond the simple need for the AMHP to ‘inform’ the NR that s/he intends to use powers under the MHA, but also to conduct an assessment. The MHA seeks to ensure *that all the circumstances of the situation are understood and all views are heard and weighed up proportionally by the AMHP*. The ability of the NR to challenge is further bolstered by the fact that, should detention occur, the NR can apply to the first-tier tribunal to have the detention reviewed. The NR has also the power to order the patient’s discharge from detention¹⁰ in hospital under Section 2¹¹ or 3¹², or on a Community Treatment Order under Section 17A, by giving 72 hours’ notice in writing to the hospital managers. Although this order can be similarly blocked¹³, it can only be blocked if the detained person is assessed to be ‘dangerous’. If s/he is not deemed to be dangerous, the tribunal must discharge the person, as the threshold for detention would not be met.¹⁴ A relative who has been displaced by the court can also periodically apply to the tribunal, even though they are no longer undertaking the functions of the NR role. No such medical power to block a NR discharge order exists for guardianship, and no NR power of discharge exists for patients who are mentally disordered offenders and detained under section 37 of the MHA.

Finally, the NR can make an application under section 11(1) for compulsory detention under Section 2,¹⁵ 3 or 4¹⁶ or apply to receive a person into Section 7 for guardianship. The MHA does not demand much from the NR as an applicant, as it does not require any special skills or training on the part of the NR.¹⁷ Although the NR has this power, the Code of Practice (DoH 2015) recommends that the AMHP should usually be the right applicant (DH 2015:14.30). Given what has been stated above, the NR as applicant is potentially seen as the exception. Although within the Code of Practice (DH 2015:14:50) there is a challenge to

¹⁰ Under Sections 23(2) and 25.

¹¹ Up to 28 days for assessment.

¹² Up to 6 months for treatment.

¹³ Section 66.

¹⁴ Section 72.

¹⁵ Application for assessment in hospital.

¹⁶ Short-term/urgent admission to hospital.

¹⁷ Section 11(5).

the AMHP in that s/he must consider if they are the correct applicant, and not the NR. This aspect of the role does potentially cause tension as it could be viewed as adversarial in nature, and stands in contrast to the other NR functions, which are intended to be more supportive of the patient.

These three broad functions of the NR should, in any event place, the NR more centrally in the decision-making process, unless the AMHP has reason to believe that to do so would be harmful to the person they are assessing. On the face of it therefore, the role of NR is a powerful one, but it can only be effective when the holder is fully aware of the duties, powers and rights and how to use them. In this respect, the NR role is very different to the 'next-of-kin,' as the latter offers no legal authority within the MHA, even though, as a concept, it is more readily in the contemplation of the public. Identifying who the nearest relative is relies initially on the duty of the AMHP to *reasonably* identify who the NR *appears to be*. This imperative can be problematic and complex, as there are opportunities for errors, primarily arising from the complexity of human relationships and their current legal status at the time of the assessment, as well as potential confusion among relatives about the legal differences between the rights of NR, carers, and the next of kin. This issue is further explored below. Nonetheless, the express wishes of family (with the NR) need to be heard by the AMHP¹⁸ through consultation and information sharing,¹⁹ and, reciprocally, the NR needs to be informed of his/her powers and duties. This is important, as it is likely that most the population do not know that they could be a NR, or have a NR for the purposes of the MHA. For this reason alone, the AMHPs central position to enable and empower the NR with this knowledge should not be underestimated.

The duty of the AMHP to identify the NR involves negotiating the complexity of sections 26, 27 and 28 of the MHA (DH 2015:14.57). This comes at a time when the AMHP is in the process of undertaking a MHA assessment, which has been likened in one study to walking a 'tightrope' (Dwyer, 2012). The list of eligible family members who can fulfil the role is contained within section 26(1) and can seem somewhat arbitrary. It reflects parliament's views of who should be a relative, which curiously excludes relations such as cousins, but

¹⁸ S. 13(1).

¹⁹ Sections. 132 & 133.

includes unrelated individuals who have lived with the patient for more than 5 years. The application of section 26 could also result in an appreciation that the meaning arising from these sections is prescriptive but not necessarily intuitive for the circumstances in which the relevant person may find themselves. Prioritisation is given to enable the AMHP to decide which relatives should take precedence and the practicability of consulting. Due consideration is given to their position in section 26(1), including factors such as their relationship, age, residence, blood-line, and whether they offer care. Also, AMHPs must consider the impact of whether a lack of 'parental responsibility' invalidates a father from being a NR to their children.

In addition to the complexity of the AMHP's task, there are other fundamental challenges to appointing the NR. First, the MHA assumes that the person who appears to be NR would be content to act as such when there is no legal obligation to do so. Secondly, there is also an implicit assumption that the NR will act in the relevant person's best interests, but as considered below, this is not always the case. Thirdly, the Act assumes that the NR is readily available for the AMHP to communicate with or has the mental capacity to reach a decision within their powers and duties. Finally, the provisions assume that each citizen has a NR that can be identified, when the reality can be very different, as will be explored further below. In these circumstances, section 29 can be used to appoint (or displace by removing them) as a NR. This can be achieved by an application from an AMHP, the relevant person (DH 2015:5.6), a relative or a person residing with the relevant person to County Court (DH 2015:5.10). This mechanism may be used whereby a NR unreasonably objects to an application for section 3 admission by an AMHP, or when the relevant person/local authority believe that it is not practicable for the NR to act as such. Here, the County Court would empower an acting NR (DH 2015:5.7). Furthermore, a NR may, in any event, delegate their 'functions' as NR to another suitable person if needed (DH 2015:5.5) until further notice, or for a limited time. The relevant person may also take some comfort that they can apply to county court themselves to seek appointment of a different NR (DH 2015:5.6) in line with human rights considerations.

There are also, curiously, some exclusions to the powers of the NR for some categories of patient.²⁰ Similarly for those who are either Section 131 informal or voluntary patients there is no NR protection provided. This means that although there might be a person who would have been eligible to act as NR, they are powerless to act as such. Also, to act as a NR a person must have attained the age of 18 years, or 16 years if married or a civil partner to the relevant person for whom detention is being discussed.

Overall, the Code of Practice (DH 2015:5.2) reinforces that the AMHP should always re-determine who the NR is in, light of a person's circumstances, but it equally brings into question the robustness of the safeguard which the NR role can in fact bring if there is insufficient certainty and choice. The implication is that there are plenty of opportunities for errors in NR identification and involvement. Particularly as the AMHP seeks to strike the appropriate balance between Article 5 (which protects a person's right not to be arbitrarily deprived of their liberty) and Article 8 (which protects a person's private and family life) of the European Convention of Human Rights (ECHR). It is to the legal and human rights based aspects of the NR provision that we now turn.

An effective legal safeguard?

As outlined above, the NR has several powerful duties and is intended to be an important and independent legal protection for patients. Indeed, the government's White Paper which outlined proposals to reform the MHA in 2000 recognised the key role of carers and family members (DoH, 2000: 47) as a safeguard to protect patients in the compulsory admission process. In this context, the NR's power to object and the procedures that must be followed by the AMHP during the compulsory admission process are significant to protect the right under Article 5 of the ECHR, as the case of *TTM v London Borough of Hackney*²¹ demonstrates. In this case, the patient had been admitted under section 3 to hospital, but challenged the lawfulness of his detention on the basis that there had been a breach of Article 11(3) as the NR had objected to the application. The court concluded that, on the

²⁰ Those subject to either Section 35, 36, 38, 41, 45A 47, 49 MHA or a combination do not have a NR.

²¹ [2011] EWCA Civ 4.

facts of the case, the patient's right to liberty under Article 5 had been infringed. He had been unlawfully detained and was entitled to compensation.

In this sense, the NR role to challenge and object can provide a key legal protection. However, ECHR rights must be carefully balanced and Article 8 has led to some significant challenges to the NR provision, which suggest that the safeguard is, in some respects, still 'fragile' (Gostin, 1975: 44). Indeed, the NR provisions have generated some considerable jurisprudence, and cases have shown that the NR role can sometimes be open to abuse as some relatives are not best placed to support the patient in this way. Several cases have highlighted this risk and reinforced that the patient should be at the centre of decision making about the choice of NR, to promote his/her Article 8 right to a private and family life under the ECHR. One such case is *R(E) v Bristol City Council*²² where there had been a breach of the patient's rights under Article 8 in relation to the suitability of the appointed NR to act. Briefly, the facts of the case were that E (the patient) did not wish her sister (Mrs. S) to be involved with her care and E's psychiatrist considered that it would be unhelpful to E's mental health for her sister to act as her Nearest Relative. On an application by E that it was unlawful for the Local Authority or its Approved Social Worker (which preceded the AMHP role) to notify or consult E's sister (as NR), without first obtaining E's consent, the court concluded that:

*'It would seem clear to me that this Mrs S is not an appropriate person to carry out the many powers and responsibilities given to her as the claimant's nearest relative under the Mental Health Act 1983. I say that because (i) the claimant does not want her as her nearest relative, (ii) it might be positively harmful to the claimant's mental and emotional well-being for Mrs S so to act, and (iii) Mrs S, it seems, does not wish so to act.'*²³ [9].

Cases such as this cast doubt on the adequacy of the safeguard and highlight the potential tensions in the role when NR are given potentially conflicting powers to challenge the use of compulsion, as well as making an application for compulsory admission. As the Court of

²² [2005] EWHC 74.

²³ Ibid. at [9]. Though note that this case must now be read in the light of *TW v Enfield BC* cited below.

Appeal recognised in *TW v Enfield Borough Council*,²⁴ a careful balance must also be struck between the patient's rights under Articles 5 and 8 of the ECHR (as well of course, as the Convention rights of other family members). The NR straddles many such rights and this can present challenges for AMHPs working with the legislation on a daily basis, often in a mental health crisis, when decisions must be made quickly. Indeed, it is significant to note that the first declaration of incompatibility with the ECHR under the Human Rights Act 1998 made by the domestic court was in *JT v UK*,²⁵ in relation to the NR provisions. The case involved a patient whose stepfather was said to have sexually abused her and she did not wish her NR, (her mother, who still lived with the father) to be involved in decisions about her care. The Commission unanimously concluded that there had been a violation of Article 8 of the ECHR and the UK government at the time undertook to amend the law to rectify the incompatibility and enable patients to exercise some control over the choice of nearest relative. This was undertaken as part of the reform process in the mid-2000s and patients can now apply to the court to displace an 'unsuitable' NR under s. 29. However, this falls considerably short of giving the patient complete autonomy to nominate or appoint their preferred person (relative or carer) to act as the NR in the first place. There are also criticisms of the displacement process, which can be cumbersome and time consuming. These displacement difficulties and delays have been recognised by the court on several occasions, and again, potentially compromise the patient's right under Article 8.²⁶

The fragility of the NR as an effective safeguard and human rights protection must also be re-assessed now in the light of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is an international treaty passed by the United Nations General Assembly in December 2006, which came into effect on 3rd May 2008. The UK ratified the CRPD in July 2009 and the government has recently indicated that it will continue to be a signatory to the CRPD.²⁷ The Convention is intended to promote equality for all people living with disabilities as defined in Article 1: 'persons with disabilities include

²⁴ [2014] EWCA Civ 362.

²⁵ [2000] ECHR 133; See also *M v UK* 30357/03 [2007] ECHR 206; *FC v UK* (1999) 37344/97 [1999] ECHR 184.

²⁶ See for example judicial dicta in *R (MH) v Secretary of State for Health and others*; and *R(S) v City of Plymouth* [2005] UKHL 60.

²⁷ House of Lords, Written Question, HL 5380 (8 February 2017), available at <http://www.parliament.uk/written-questions-answers-statements/written-question/lords/2017-02-08/HL5380>.

those who have long term physical, mental, intellectual or sensory impairments'. The treaty adopts a broad conceptualization of disability as an 'evolving' concept, to include both long-term physical and mental impairments i.e. people with a mental illness, learning disability and psycho-social disabilities. It adopts a new paradigm for human rights, as it re-conceptualizes rights specifically for people with disabilities (Lawson, 2008), by adopting the social model of disability. This model locates the barriers faced by disabled people within society rather than the person him/herself.²⁸ Accordingly, the CRPD requires national governments (as convention signatories) to remove barriers to promote equality of treatment for all people with disabilities. The convention is underpinned by an 'ideology of inclusion' (Jones, 2005: 186) and its core principles promote, *inter alia*, autonomy, dignity, equality, non-discrimination and active participation of people with disabilities in all aspects of life. A report by the EU Agency for Fundamental Rights has recognized that the rights of people with mental health problems have been significantly enhanced and strengthened internationally by treaties such as the CRPD over the past decade:

'At the international level, there has been significant evolution in the approach to persons with mental health problems..... This shifting approach is reflected in the various instruments developed at the level of the UN which address the rights of persons with mental health problems... In this context, the CRPD marks the latest stage in the paradigm shift away from a view of disability centred on medical impairments, to one where the full, and equal, rights of persons with disabilities are accepted' (2011; 9).

The CRPD enshrines numerous rights for people with disabilities, including civil and political rights, such as the right to liberty and freedom from inhuman/degrading treatment, as is found in the ECHR. But it goes further than the ECHR, as it also promotes a range of positive social and cultural rights, such as the right to education and to health care. As Kayess and French have argued, *'it seems clear that [the CRPD] has, in fact, modified, transformed and added to traditional human rights concepts in key respects' and transformed non-interference rights 'into positive state obligations'* (2008: 1)

²⁸ In contrast to the medical model which locates the disability within the disabled person. This approach views disability as an impairment within the individual that requires treatment or intervention.

The CRPD's focus on individual autonomy means that governments will be increasingly required to consider and respect the person's own view of their relationships. The ability to exercise individual choice over the appointment of a NR must be a key factor in any re-appraisal of the NR role. As Donnelly and Murray have identified, the concept of 'relational autonomy' is useful to consider here (2005; see also Nedelsky, 2011), as it accepts that relationships are intrinsic to human existence, but that not all relationships are benign. Accordingly, we must also respect an individual's right to, 'extricate themselves from bad relationships as well as... transform[ing] the structures that shaped those relationships' (Nedelsky, 2011, p. 32). Specifically with respect to support mechanisms for persons with mental disabilities, Article 19 of the CRPD places a positive duty on Governments to provide a range of community supports to live independently and be included in the community. This includes a right to choose both place of residence and their particular living arrangements. This should enable people with disabilities to choose how and with whom they would like to live, and governments will need to engage with families and the community more widely in order to protect and promote this right. This is clearly relevant to the functions of the NR role and their direct involvement in care/treatment decisions.

The ECHR has often been described as providing a floor for basic rights protection, and other human rights instruments have significantly expanded rights-protection, above and beyond the ECHR in many areas.²⁹ The CRPD brings with it the promise to further strengthen the rights of persons with mental disabilities in the UK, provided of course that the government is willing to take appropriate action to implement it. Although the doctrine of duality in international law means that the CRPD is not directly enforceable in the same way as the ECHR, there are some positive signs that it is already exerting some influence on the development of law and policy, and featuring in a persuasive manner in the

²⁹ See for example 'Article 47 of the Charter guarantees a 'fair and public hearing within a reasonable time by an independent and impartial tribunal', but is not restricted to 'determinations of civil rights and obligations' like ECHR Article 6. This is deliberate: correspondence with ECHR-guaranteed rights does not preclude 'more extensive protection': see Article 52(3) of the Charter' in Fordham. M., *Common Law Rights*, pp. 4 and 8, available at http://www.publiclawproject.org.uk/data/resources/76/PLP_2010_Fordham_QC_paper_Common_Law_Rights.pdf.

jurisprudence of national courts.³⁰ For example, in *London Borough of Haringey v Lush*³¹ the judge expressed the view that: 'Although it does not form part of our domestic law, it may have an interpretative influence, particularly in cases affecting the rights of a person with a disability'.

Related to the rights and entitlements enshrined in the CRPD is the relationship between the NR and other key players in the compulsory detention process. The MHA 2007 introduced new protections for patients through Independent Mental Health Act Advocates (IMHAs)ⁱ introduced by the MHA 2007.³² Patients are eligible for an IMHA in cases where they are liable to be detained, are subject to a guardianship order or are a community patient.³³ IMHAs are professional advocates who are commissioned by local and national bodies. Broadly speaking, the role of the IMHA is to help patients access and understand information about their detention and treatment and to help them exercise their legal rights, such as their right to appeal.³⁴ The IMHA's functions can be seen to overlap with that of the NR or carers more generally, in that each may have a role in supporting and helping the patient to understand information and make their views known. This overlap is evident in the sections of the Code of Practice concerned with making the patient's voice heard. For example, the Code states that:

Often carers or advocates can help with or advise on the best ways of communicating with a patient (DH, 2015, para 4.5).³⁵

However, it should be noted that the MHA 2007 has given IMHAs specific powers that are not afforded to the NR. Specifically, IMHAs have the power to interview patients in private,

³⁰ See for example the Law Commission in England and Wales' comments in its recent consultation paper on *Mental Capacity and Deprivation of Liberty Consultation Paper No 222*. (2016 London) at para. 3.22: '*The UN Disability Convention challenges existing understandings and categorisations of disability rights. There is much in its terms to be enthusiastic about. Its full implications are still being grappled with by governments across the world.*' located at <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>.

³¹ [2014] EWCOP B23.

³² Section 130a and 130b MHA 2007.

³³ Outlined under section 130C. Those subject to emergency, short term and detention under s. 135/136 (by the police) are not eligible.

³⁴ Section 130B (1).

³⁵ See also DH, 2015, paras 4.8 and 4.38 for examples of this.

to interview mental health staff and to request and examine patient records.³⁶ The MHA 2007 recognises that NRs may wish to work in conjunction with IMHAs to protect patient rights. NRs are eligible to receive the same information about the IMHA services as the patient, except where the patient requests otherwise.³⁷ Furthermore, an IMHA should comply with any reasonable request to visit and interview the patient made by the NR.³⁸ Whilst the recognition that NRs may act to protect patient rights exists, IMHAs may also be utilised in order to limit NR rights. This is recognised in the Code of Practice when discussing when an AMHP might displace a NR. AMHPs are encouraged to find alternatives to making an application for displacement where possible, including the consideration of a referral to an IMHA to enable them to make the application for a displacement themselves (DH, 2015, para. 5.16).

In the light of the above analysis, the CRPD creates an opportunity for the UK government to re-evaluate and re-focus the rights of patients and role of relatives/carers and how they (and others) can support patients more effectively in the compulsory admissions process. As we have argued, the MHA 1983 drew on assumptions that NRs might act as advocates to the patient. However, as we have demonstrated, case law has recognised that NRs may not always be regarded as helpful by patients. In addition, the CRPD has reinforced an individual's right to make choices about their care, treatment and social networks. The revisions made to the MHA 1983 by the MHA 2007 extended the scope of patient autonomy in that they have provided a mechanism for displacement of the NR. They have also increased the range of people who may advocate for the patient through the introduction of the IMHA role. However, the ability of patients to choose who might advocate on their behalf remains severely limited. The ability to displace remains a weak safeguard in that patients are required to do so when they are at their most vulnerable. Furthermore, the differences between the support and 'advocacy' that NRs and IMHAs might be expected to provide are weakly stated in law and guidance. The need to reconsider the NR role is also pressing as, despite, the modifications in 2007 to the NR role outlined above, there are still

³⁶ Section 130B (3). Section 130B (4) MHA 2007 also identifies that these powers may not be used where a patient with mental capacity refuses or where these powers conflict with the wishes of a donee or deputy appointed by the court of Protection.

³⁷ Section 130D (5) MHA 2007.

³⁸ Section 130B (5) MHA 2007.

concerns about the extent to which some carers/relatives are suitable and able to provide an objective and effective NR protection for patients. It is to this aspect that we now turn and examine the literature relating to the extent to which relatives/carers can provide a meaningful 'expert' voice in care and treatment decisions.

Relatives and Carers as Experts?

The 1990s saw a shift in language within adult and mental health care policy in which the use of the term 'carer' increased and references to NR's decreased (Rappaport, 2004). For this reason, we focus on the way in which recent policy towards carers impacts on the NR role, focussing specifically on the growing emphasis in policy of treating carers as 'experts'. Drawing on research, we explore some of the practical challenges of treating carers as experts; focussing on the degree to which patients and carers agree about compulsory admission and on the way in which admission may affect relationships and family wellbeing, as well as patient recovery.

In recent years, the government has signalled its intention to promote the rights of carers within adult health and social care policy. Policy documents under the new Labour (DOH, 2008) and coalition governments (DOH, 2010a) noted that carers were often excluded by health and social care professionals, found the process of accessing a carers assessment difficult, and were often not supported to achieve a life outside of caring. Whilst previous policy had already sought to address the needs of carers (DOH, 1999), the 2008 document provided a target that carers would be respected as 'expert care partners' by 2018 (p. 9) and would be provided with personalised support, reflecting individual need. Carers policy since 2008 can be seen to draw on key policy assumptions around 'personalisation'; mainly that people are expert in their own lives (Needham, 2011). On a general level, this policy narrative can be viewed as a challenge to professional power, highlighting that professionals should err towards facilitating rather than directing care. However, these policies also sought to correct an individualised focus on patients. For example, practice guidelines on carers and personalisation open with a statement by the Chair of the Standing Commission on Carers. She argues that: 'historically there has often been too much of a divide between the user and the carer, whereas the physical and emotional well-being of both are

inextricably linked'. (DOH, 2010b, p. 5). Drawing on these documents, mental health policy (HM Government, 2011) argues for mental health carers to be treated as 'equal partners' noting that concerns about confidentiality have been commonly misused as a reason to exclude them. Whilst mental health policy has promoted the role of carers as experts, the role of carers in the MHA assessment process is more confined than it is under the mental capacity legislation and 'is regarded as being of less significance in the statutory schema than the protection afforded by clinical judgment of those exercising their functions under the Act' (Keywood, 2003; 2010; 330). Indeed, there are cases suggesting that professional/clinical views may be elevated above those of nearest relatives in some circumstances.³⁹ This problem was recognized by Lady Justice Hale (as she then was) in *S v W* (a case involving a NR displacement application) when she stated that:

*'...this case illustrates several aspects of the mental health law which give rise to the greatest possible sense of injustice on the part of patients and from time to time their families..... it illustrates the overriding of the views of the nearest relative, and in practice how difficult it is for the nearest relative to avoid being found unreasonable if his views differ from those of the hospital'.*⁴⁰

Current policies towards carers should be welcomed in so far as they encourage greater thought about how the needs of carers can be met. However, they tend to gloss over differences of opinion between users and carers that may exist. Research into the views of patients towards family involvement is limited, but suggests a mixed picture. For example, a US study by Cohen et al (2013) found that 78% of patients wanted their carers to be involved in their care. Qualitative research throws some light on potential reasons for differences in view with a study by Aldersey and Whitely (2015) finding that users believed that family involvement might enable or impede recovery. Families were viewed as limiting recovery in cases where they acted as a stressor, expressed stigmatised views about the person's mental health problem or where they forced hospital admission.

³⁹ See for example in the context of a displacement application *R v Central London County Court ex parte London* [1999] 3 WLR 1.

⁴⁰ [2000] EWCA Civ 3025 at [14] and [15].

As outlined above, the main powers that NR have related to facilitating or preventing a compulsory admission to hospital. However, this is an area where differences in opinion between patients and carers are at their most stark. Quantitative research has consistently found that carers rate compulsory hospital admissions more positively than patients. These studies have measured levels of perceived coercion by patients admitted to hospital (covering the degree of influence, control or choice that they felt they had over admission) (Hoge et al, 1998; O' Donoghue et al, 2016). Views of perceived coercion by patients has been found to be strongly related to their perceptions of procedural justice during admission (i.e. the degree to which they were involved in decision making as well as the level of force experienced) (Hoge et al, 1998). When comparisons have been made between the views of patients and carers, studies have found carers rated levels of coercion as being lower than patients (Hoge et al, 1998; Giacco et al, 2012; O' Donoghue, 2016). In addition, carers rated procedural justice as being more satisfactory than it was perceived by their relatives detained in hospital (Hoge et al, 1998; O' Donoghue et al, 2016). However, whilst research indicates that carers have high levels of satisfaction towards the treatment that their relatives receive in hospital (Giacco et al, 2012), this does not necessarily mean that they are happy with mental health services *per se*. Qualitative research indicates that carers often do not know how to access support prior to admission or experience mental health services as unreliable (Jankovic et al, 2011). In cases where community support is provided, carers experience services as reactive rather than pro-active, which is felt to increase the likelihood of admission (*ibid*). Furthermore, carers felt that professionals did not involve them in decision making (Wilkinson and McAndrew, 2008) whilst at the same time expecting them to provide care to avoid admission or facilitate discharge (Jankovic et al, 2011).

Potential impact of the NR role on patient wellbeing and recovery

Our understanding of the impact of enacting the NR role on the relationship between the patient and NR is extremely limited; nor do we properly understand the impact of this role on the wider family and caring system, due to the lack of research in this area. The MHA's pre-determination of a single individual to perform the NR function, irrespective of the quality of relationship with the individual patient, may have implications for all involved. It is

possible that the hierarchy determining eligibility for the NR role may disenfranchise important individuals in the caring system, as was the case for gay and lesbian partners before 2002, prior to *R v Liverpool City Council (1) Secretary of State for Health (2) and LS (Interested Party)*⁴¹ (Cho, 2002). Amendments made to the MHA in 2007 rectified this anomaly to ensure that civil partners are treated in the same way as spouse in the NR hierarchy but there are still other familial relations who may be excluded from the role.

Systemic models of psychological distress identify mental health problems as existing within a family or relational context, where patterns of relating have implications for continuance or improvement of difficulties. Hospital admission is a stress which can disrupt the family life cycle resulting in dysfunction within a family or caring system (Carter & McGoldrick, 1999) which may increase distress and mental health problems for all involved. It can also have implications for recovery, as functioning social support enhances resiliency (Guidances & Watch, 2007). Whilst the powers and rights given to the NR may be welcomed by all parties in some cases, in others the NR may experience this role as an unwanted responsibility, which creates stress for them and increases tensions in relationships around them if disagreements exist. The fact that family members have their own views and interests, some of which may conflict with those of the patient, may make it difficult for NRs to carry out their advocacy related functions. This is especially so if we consider what advocacy implies. As Keywood has identified:

‘A key dimension of advocacy lies in the independence of the advocate, in order that no conflict of interest arises between advocate and care recipient’. (2003: 363)

There is also an absence of research into how patients and NRs reconcile decisions made about compulsory hospital admission, or indeed whether patients are frequently aware that a specific individual will have been asked to act in this way. In the most easily reconciled scenarios, a patient would freely agree that the decision to admit was in their best interests once the crisis requiring admission resolved; however, considering the discrepancy between patient and carer views on satisfaction and levels of coercion in mental health treatment

⁴¹ CO1220/2002

(Hoge et al, 1998; Giacco et al, 2012; O' Donoghue, 2016), it is likely that differences in views persist. It is unclear whether some patients experience the NR's lack of objection to admission as a betrayal. This may have implications for the mental wellbeing of both patients and NRs, as betrayal has been associated with the genesis of certain mental health problems, such as obsessive compulsive disorder; personality-focused problems; depression; anxiety and physical ill-health (Rachman, 2004; 2010; Kaehler & Freyd, 2009; Goldsmith, Freyd & DePrince, 2011). Thus, it has the potential to compound psychological distress. Furthermore, being compelled to betray another – as may be the interpretation of the role by some NR who are asked to perform it, particularly in relation to the potentially adversarial functions – has been found to result in potentially distressing experience of 'mental contamination' (i.e. feeling pervasively unclean and needing to wash (Coughtrey *et al*, 2012; Waller & Boschen, 2015). Jankovic *et al* (2011) found that family care givers experience mixed emotions of relief, guilt and worry about compulsory admission of their relative, although it is unclear whether such responses were affected by the assumption of legal powers to dispute admission as the NR. Further research with both patients, NR and the extended caring network is essential to understand the implications of this role for relationships, family wellbeing and recovery, with a view to helping to shape any future reforms to the statutory role and functions.

Professional and lay (mis?)understanding

In the following section, we move on to consider some of the practical problems that exist in relation to the NR role. Specifically, we focus on problems that AMHPs may experience on the ground in attempting to identify a patient's NR and, linked to the preceding discussion, the challenges that NRs may experience in exercising their role.

AMHPs have legal duties to inform or consult NRs at different points throughout the admission process which have been described by the court as 'heavy' duties.⁴² Stuart Smith has also observed that:

⁴² *GP v Derby City Council* [2012] EWHC 1451 (Admin)

'A difficulty faced by those in caring professions is that mental health act assessments and admissions are a bureaucratic-administrative process as well as an emotional experience and there is frequently a tension when attempting to address all aspects of this process at the same time' (2015; 345).

These difficulties are particularly acute for AMHPs in their contact with NRs. The first difficulty for AMHPs is deciding who should be identified as the NR, a process which has been described as the *'identification lottery'* (Spencer-Lane, 2011: 50). As mentioned previously, section 26 (1) of the MHA sets out a hierarchy of family members who should be considered, with a patient's husband, wife or civil partner being listed at the top, followed by a list of other relatives including children over 18, parents and adult siblings. This list has historical origins, as Rappaport has commented, drawn from a hierarchy *'based on British genealogical traditions, intentionally "the person closest in affection rather than nearest relative in kinship"'*. (Rappaport, 2003: 53). But it is nevertheless intended to be flexible, so that relatives at the bottom of the list may trump those at the top if they live with the patient or care for them. The difficulty for AMHPs is that legal definitions of who should count as a family may run counter to contemporary everyday understandings the reality of the dynamics of familial relationships. For example, uncle and aunts are listed within the hierarchy of relationships under section 26 (1), although only some uncles and aunts may be identified. Barber et al, note that *'it would seem that only blood relationships would count here, so that your mother's brother is your uncle, but this uncle's wife is not your aunt for the purposes of the MHA 1983. This is a recipe for confusion'* (2009, p. 105). By contrast, the identification of who should be identified as a carer has been ruled to be a matter of professional judgement, in which AMHPs should *'act in a common-sense manner'*.⁴³ The Act requires AMHPs to exclude relatives within the hierarchy where they are not ordinarily resident in the UK, Channel Islands or Isle of Man (section 26 (5(a)), or in the case of a husband, wife or civil partner have separated from them (section 26 (5(b))). There is also some ambiguity surrounding the status of unmarried fathers and illegitimate children (Hewitt, 2013). Finally, in the context of siblings, children and those with parental responsibility for the patient: *'the reversion to the 'eldest' relative in all cases is a crude and*

⁴³ *Re D (mental patient: Habeas corpus)* (2000).

sometimes inaccurate measure of closeness' (Stuart Smith, 2015: 341). Taken in combination, these requirements make it technically difficult for the AMHP to identify the correct NR, particularly when doing so at speed, as is often required when conducting MHA assessments in an emergency. It also begs the question: to what extent can or should we expect AMHPs to carry out extensive documentary/registry checks or seek intrusive information about personal relationships, in order to get this right?

Currently the Act does allow AMHPs a high degree of latitude when making this decision. The AMHP is only required to consult the person *appearing* to them to be the NR. In making this judgement, they need to show that they have acted reasonably,⁴⁴ having taken the statutory criteria into account. However, whilst the case law has considered the emergency nature of many section applications, it also implicitly accepts that accuracy in relation to identifying NRs may be variable and the identification of the NR test (ie. 'who appears to him to be the NR') is subjective.⁴⁵ Moreover, the amount of case law that has been generated in this area would suggest that errors are often made (albeit unintentionally) in the NR identification process, which has resulted in patients being found by the court to be unlawfully detained.⁴⁶ Again, this points to the need for greater clarity and improvements to the NR role, as it is not always acting as it should to protect patients in such cases.

A second difficulty for AMHPs is deciding *when* it might be appropriate to consult the NR. Section 11(4) of the MHA (as revised under the MHA 2007) states that AMHPs should not make an application for detention under section 3 in cases where they have consulted the NR and they object. However, the section goes on to state that an AMHP may decide not to consult a NR where, 'it appears to the AMHP that, in the circumstances (a) it is not reasonably practicable or (b) would involve *unreasonable delay*' (section 11 (4b), emphasis added). The MHA Code of Practice states that circumstances in which consultation would be deemed impracticable would be cases where identifying the NR would cause the AMHP an unreasonable amount of investigation or delay or cases where the NR is mentally

⁴⁴ *Re D (Mental Patient: Habeas Corpus)* [2000] 2 FLR 848 at [15].

⁴⁵ *R(WC) v South London and Maudsley NHS Trust* [2001] EWHC 1025 (Admin); *CV v South London and Maudsley NHS Trust* [2010] EWHC 742 (Admin).

⁴⁶ See for example *GP v Derby City Council* [2012] EWHC 1451 (Admin); *CX v A Local Authority* [2011] EWHC 1918 (Admin); *GD v Hospital Managers of Edgware Community Hospital* [2008] EWHC 3572 (Admin); *Re S-C (Mental Patient: Habeas Corpus)* [1996] 1 All ER 532.

incapable of making a decision (para. 14.60). However, where the identity of the NR is clear, there may also be cases where consultation is deemed to be impracticable due to a patient having expressed a view, either verbally or through an advance statement, that they do not wish the NR to be consulted. As the NR role is intended to be a safeguard, AMHPs will need to balance the pros and cons of consultation rather than accepting a patient's view in an unquestioning way, being mindful also of the need to protect and carefully balance the patient's rights under the ECHR. Case law has established that in making this judgement, AMHPs will need to consider the possible detrimental effects on the patient due to previous abuse and, as noted above, should also consider the patient's right to a private and family life, and confidentiality, under Article 8 of the ECHR.⁴⁷ Whilst no research has been conducted since the MHA 2007 revisions took place, Approved Social Workers (now AMHPs) in Rappaport's (2004) research noted many difficulties in the operation of the law. Specifically, some NRs might be excluded from the consultation process because their contact details had been excluded from databases or because mental health staff did not make efforts to find them due to workload pressures. Similarly, Local Authorities were viewed as being reluctant to displace NRs viewed as inappropriate by ASWs due to cost pressures.

A final point to note is that NRs are afforded considerable rights and powers but it is unclear to what degree they are aware of these, and this clearly impacts on their ability to provide an adequate safeguard. As NRs have a right to be informed about an admission under section 2 of the MHA or consulted about admissions under section 3, they should, in theory, receive information about their role from AMHPs or hospital managers. Annual Mental Health Act monitoring reports by the Care Quality Commission (CQC, 2016, 15, 14) have not reported the levels of consultation or information provided to NRs, although they have indicated in general terms that hospitals are failing to make NRs and carers aware of their legal rights (CQC, 2015, 2014). There is limited research to date on the experiences of NR, but some qualitative accounts indicate a number of potential problems with their awareness of the role. For example, a patient interviewed by the CQC indicates that not all NRs may be aware of their right to object, as the quote below demonstrates:

⁴⁷ See for example *TW v Enfield Borough Council* [2014] EWCA Civ 362 and *R (E) v Bristol City Council* [2005] EWHC 74 (admin).

‘...carers can object to out-of-area placements; some AMHPs are very good at explaining this, but some don’t.... I know carers all over the country who didn’t know that you could do that [object to admission] weren’t aware that you could step in and stop the section’ (CQC, 2016: 29).

Similarly, NRs in Rappaport’s research indicated that whilst they had been identified as NRs, they had not been or made aware that they had the power to request a MHA assessment. NRs in this study indicated that had they been aware of this power, they would have requested an assessment. They also felt that they were only able to access information about discharge decisions in cases where they were willing to be 'pushy' (Rappaport, 2003: 63). Qualitative research elsewhere indicates that this level of dissatisfaction may not be typical of all. For example, in the case of individuals who had been made subject to a Community Treatment Order, NRs felt happy with the level of consultation and felt that the order acted to improve communication between service providers and NRs (Banks et al, 2016). There is currently little research which indicates how advocacy by NRs interacts with the professional advocacy services. Research with the carers of dementia patients (Emmett et al, 2014) has found that relatives frequently see themselves as advocating for their relatives through helping them to communicate their needs and wishes. In doing so, they overlapped with professional advocates on the ward; who in this case were IMCAs. Research focussing on patient staff and carer perspectives of the IMHA service (Newbigging et al, 2014) has found that carers were largely unaware of the existence of the IMHA service; although those who were viewed the service as being of value to patients detained in hospital. There is obviously some disparity and inconsistency in the provision of information to NR about their rights and duties, and Keywood has cautioned against over-reliance on carers/ family members in the compulsory admission process without the provision of adequate training and support about the role (2003: 363). As she has identified: ‘...there is acknowledged a considerable deficit of skill and expertise among NRs performing their responsibilities under the Act’ (2010: 330)

This is indeed a key issue, and there is a paucity of information available about any guidance or support that may be available to NRs. A postal satisfaction survey of 32 NRs in 2015

indicated that, whilst NR experiences of AMHPs were largely positive, they would have valued greater levels of explanation and support from the AMHP to help them to navigate the complexities of mental health crisis intervention services (Stuart Smith: 350). There is no published information specifically on whether there is any MHA training and support for NRs, though it is likely that families are encountering similar challenges when faced with a relative in mental health crisis who may be in need of hospital admission under the MHA. Again, this points to the need for more comprehensive and up-to-date research with patients, families, carers and professionals about their perceptions and experiences of the NR system.

Conclusion

This article has outlined the unique role of the NR in the MHA 1983 in England and Wales, and highlighted some of the confusion, tensions, and challenges with the identification and exercise of the role. The analysis above has revealed that it is, at times, a fragile legal safeguard and there is some professional uncertainty surrounding the role. As a Department of Health consultation in 2015 on the rights of people with learning disability and autism has identified, the current definition in the statutory framework is problematic, as it does not reflect the reality of contemporary family relationships and dynamics. The quote below from the consultation neatly sums up the main shortcomings:

‘...the current definition simply does not reflect the complexity of people’s lives and family relationships and that it is not necessarily providing the speed and certainty intended – as well as feeling at odds with people’s rights. AMHPs tell us that they currently can be uncertain about whether the MHA has been complied with and whether they have tracked down the correct nearest relative.... Given the specific duties under the MHA of the nearest relative, it is even more important that the definition should be meaningful for the person being treated’. (DoH, 2015: 2.54-2.55),

This has inevitably led to poor understanding and some lack of awareness of the role among key stakeholders – patients, professionals and relatives/carers. The government has

recently announced its intention to review the ‘flawed’ MHA, and this article has sought to contribute to the reform debates by outlining the continuing problems with the NR provisions and emphasise the need for further research to help to shape any future reforms. There is also a need to reappraise the involvement of relatives to ensure that it is brought fully in line with the ECHR and the autonomy focused ethos of the UN CRPD. There is also scope to move towards a more ‘relational’ approach to the patient’s care, as identified by Keyword, Donnelly and others. It is therefore timely and imperative to explore the current knowledge base, the effectiveness of the safeguard and work out what challenges are faced on the ground by practitioners, patients and their families and how best they can be overcome. This will help to improve patient and professional understanding of the NR role. It will also inform future AMHP training to ensure that this safeguard is implemented effectively for the growing number of patients who are deprived of their liberty under the MHA in England and Wales. As Stuart Smith has observed:

‘While trends and fashions in social work and mental health thinking come and go, the essential needs of people in crisis have changed relatively little since earliest civilizations’ (2015: 351).

His study found that patients and NR value support, explanation and understanding from AMHPs during a mental health crisis, and AMHPs need a clear understanding of exactly what they are expected to do, to enable them to provide that much needed support and guidance to patients when they are most in need.

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